Back To You: Chiropractic & Rehab
817 Silver Spring Ave. Ste. 303
Silver Spring, MD 20910

New Patient Intake Form

Title: (Circle one) Mr. Mrs. Ms. Dr. Other ________________________

First Name ____________________ **Middle Initial** ____ **Last Name** _______________________

Address ____

City _______________________________ **State** ___________________ **Zip Code** ___________

Leave Messages on: (Circle one) Home Cell Work Don't leave messages

Home Phone (_____) _______ - _____________ Work Phone (____) _________ - ___________

Cell Phone (____)________- ________________ Email __________________________________

Date of Birth ______/______/________ **Sex:** Male Female

Social Security Number: - - Marital Status: Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other_________

Employer Data

Employer __________________________ **Occupation** ______________________________

Spouse Data (Optional)

First Name _______________________ **Middle Initial**_____ **Last Name** ____________________

Home Phone (____) _______ - ____________ Work Phone (____) ______ -________________

Spouse Date of Birth _____/_____/_________

Emergency Contact

Contact Name __________________ **Contact Phone** ____________________

Relationship to Patient ____

Doctor's Signature ____________________________________

Patient Name ____ Date __________________

How did you hear about our office? ____

Medical Conditions: (Circle all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other ________________	Fibromyalgia	Asthma	Osteoporosis

Surgeries: (Circle all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Breast Augmentation	Other _____________		

Allergies: (Circle all that apply to you)

Mold	Seasonal	Milk or Lactose	Animal
Chemical	Sulfites	Wheat/Glutens	Other

Social History: (Circle all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Drink Water:	<64 oz/day	>64 oz/day	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Sleep:	<8 hours/night	>=8 hours/night	Insomnia
Other			

Family History: (Circle all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling
Stroke	Parent	Sibling
Thyroid	Parent	Sibling
Other		

Doctor's Signature ____

Patient Name ____ Date ____________

Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson’s				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

Please list all current medications being taken

____

How are your symptoms changing? Getting better Not changing Getting worse

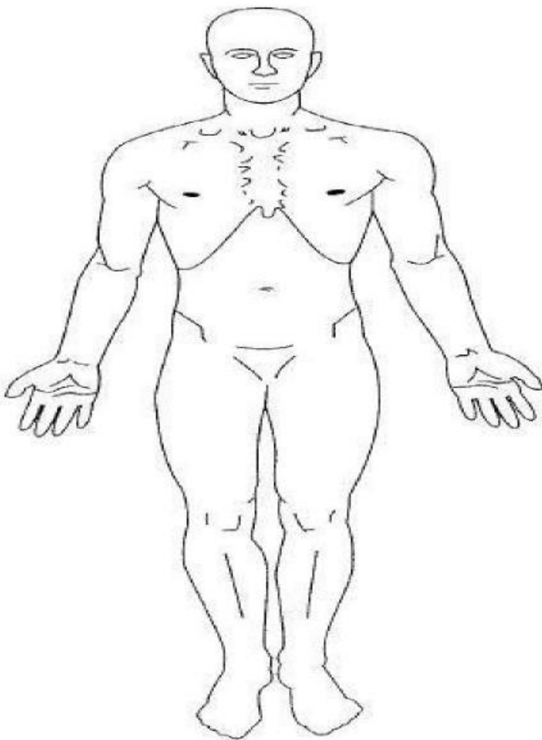
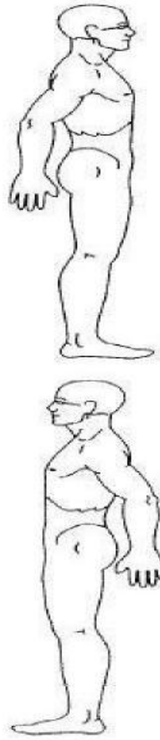
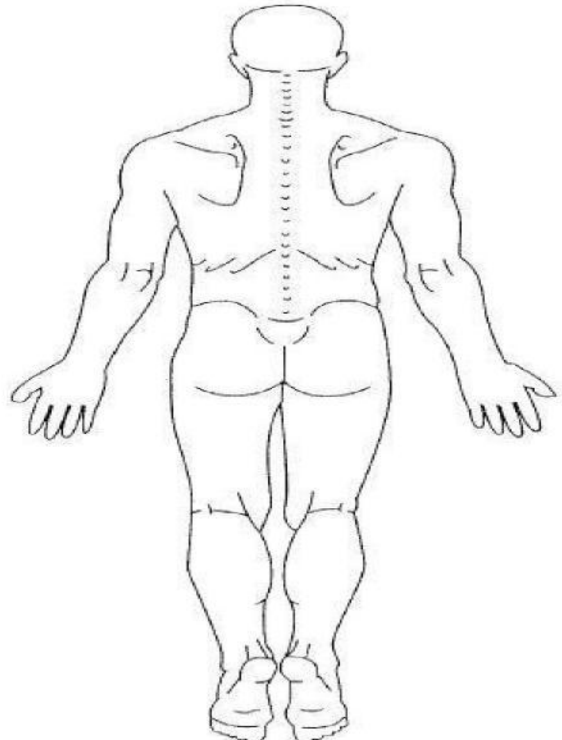
Are You Pregnant? (Circle) **Yes** **No**

Doctor’s Signature ____

Patient Name ____ Date ______________________

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness **B=Burning** **S=Sharp** **T=Tingling** **A=Dull Ache**

Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No **If Yes, please list:**

When did your symptoms begin? ____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other_____

How did your symptoms begin? ____

____

How often do you experience your symptoms?

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

What describes the nature of your symptoms?

Sharp	Ache	Numb	Shooting
Burning	Tingling	Throbbing	Other_______

Doctor's Signature ____

Patient Name ____ Date______________________

Payment/Insurance Information:

Who is responsible for your bill? Self Health Insurance Spouse Worker's Comp

Auto Insur. Medicare Medicaid Other

Personal Health Insurance Carrier: _______________________ Ins. Card ID # _____________________

Policy Holder's Name:___________________________________ Group # _________________________

Policy Holder's Date of Birth ______ / _____ / ______ Primary Care Physician _____________________

For Work-Related Injuries (Workers Compensation)

Workers Compensation Insurance Carrier: ______________________________ Claim#: ___________________

Date of Injury: ____________ Employer at the Time of the Accident: _____________________________

Was the Injury Reported to the Supervisor: YES NO

How Did the Injury Occur?: ____

Were you Treated by Another Doctor for this Injury Prior to Entering this Office: Yes No (Circle) _______________ *(name)*

Attorney Name & Address, if applicable: ____

For Automobile Accident / Personal Injury Accidents

Automobile Insurance Carrier: ________________________________ Claim #: _______________________________

Date of Accident: ________________ Location of the Accident:_______________________________________

How Did the Accident Occur: ____

Attorney Name & Address, if applicable: ____

***** Patient Authorization *****

I, _______________________ **(YOUR NAME)** , hereby authorize Back To You to apply for benefits on my behalf for covered services rendered at the facility. I request payment from _________________________________ **(INSURANCE COMPANY NAME)** be made directly to Back To You. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any other related claim. I permit a copy of this to be used in place of the original. This authorization may be revoked by me or above named carrier at any time in writing.

Patient Signature: ____ Date: _____________________

4805 West Braddock Rd. #11 Aexandria, VA 22311
Phone: (301)755-1997 Fax: (301)-560-8408

INFORMED CONSENT

To All of Our Valued Patients:

Every type of healthcare procedure and/or treatment is associated with some degree of risk. This includes chiropractic care. We want you to be informed about potential problems associated with chiropractic healthcare before consenting to treatment.

Chiropractic adjustments involve the moving of joints in the body with the use of the doctor's hands, use of a machine, use of a mechanical table, or use of a hand held instrument. Frequently, adjustments create a "pop" or "click" sound/sensation in the area being treated.

NATURE AND PURPOSE OF CHIROPRACTIC PROCEDURES

The practice of chiropractic includes many standard examination and testing procedures. These include physical examination, orthopedic and neurological testing, palpation, specialized instrumentation's, laboratory tests, radiology examinations, physical therapy and rehabilitative procedures.

There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. A chiropractic adjustment is the application of a quick precise movement over a very short distance to a specific segmental contact point of a vertebra.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.
All chiropractic physicians providing care at Back To You are licensed by the Maryland Board of Chiropractic and Massage Therapy Examiners and Virginia Board of Medicine in accordance with state laws.

POSSIBLE RISKS ASSOCIATED WITH CHIROPRACTIC PROCEDURES

Not only should you understand the benefits of chiropractic care in restoring and maintaining good health, but also you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contraindicate care, but should be considered in making the decision to receive chiropractic care. All health care procedures, including those used in varying degrees, have some risks associated with them. Risks associated with some chiropractic adjusting procedures may include:

- Stroke
- Verterbral disc herniation
- Soft tissue injury
- Rib fractures
- Physical therapy burns
- Soreness

I hereby give consent to Back To You and its employees and/or contract personnel to render treatment to myself and/or my child (or child under my guardianship). This includes all necessary examinations, treatment, and any other related procedures necessary to provide chiropractic care. I understand that treatment will be based on the physician's professional judgment.

____
PRINT NAME

____ __________________
SIGNATURE OF PATIENT / PARENT OR GUARDIAN DATE

817 Silver Spring Ave. #303 Sliver Spring, MD 20910
Phone: (301) 755-1997 Fax: (301) 560-8408

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

The execution of this form does not authorize the release of information other than that specifically described below. Your disclosure of the information requested on this form is voluntary. However if the information including social security number is not furnished completely and accurately, Back To You may be unable to comply with the request.

Patient Name ___________________________________ DOB ____/____/______

Social Security Number _____ -- _____ -- _________

The medical records and information indicated below are to be released to the following entity and its authorized representatives:

Back To You
Dr. Lukumon Adisa
817 Silver Spring Ave. #303
Silver Spring, MD, 20910
Phone: (301)755-1997 Fax: (301)-560-8408

By my signature below, I request and authorize (indicate name and address of organization or individual from whom the information is requested) to release personal health information as indicated:

____
____
____

Information Requested Includes:

_____all medical records ____billing statements ______radiology/lab reports
_____ intake/registration forms _____other____________________________

This authorization is effective for ***one (1) year*** *from the date signed unless revoked or terminated by the patient or patient's personal representative.*

You may revoke or terminate this authorization by submitting a written request to Back To You Attn: Medical Records at the address listed above.

____
SIGNATURE OF PATIENT, GUARDIAN OR REPSONSIBLE PARTY *DATE*

Back To You
Dr. Lukumonu A Adisa DC, LLC
817 Silver Spring Ave. #303
Silver Spring, MD 20910

PATIENT POLICIES

Back To You offers its patients a no waiting room environment by providing on-site, on-time services via house calls. I have established these policies to streamline the process of giving you comprehensive wellness care from your chiropractor.

Standard Appointment Times and Fee Schedule
New patient appointments range from 30 to 40 minutes with a new evaluation appointment fee of $100 and established patient appointments are 30 minutes with fees ranging from $50-80. The fees account for the scope of assessment, depth of case management, services rendered, and length of treatment. I customize my services for each patient, so I will determine the specific time and cost for each appointment. Note that Back To You reserves the right to provide an alternative fee schedule based upon location of our services.

Payment and Billing
Patients are responsible for all charges, and payments for services are processed via the debit or credit card on the patient's file on the next business day following each appointment. For your convenience, I process payments via debit or credit card and accept VISA, MasterCard, Discover, AMEX, or personal check. Payment plans are offered with 0% interest. After each appointment, I will provide you with a superbill (i.e. medical statement) that you can submit to your private health insurance carrier or flexible spending account for reimbursement, if desired.

24-Hour Cancellation Policy
I aim to provide my patients with comprehensive, personalized care. Because of the house call model of Back To You, accessibility for my patients and efficient scheduling are top priorities for me. ***A fee of $40 will be charged for missed appointments and appointments that are cancelled or rescheduled with less than 24 hours notice after one warning.***

Patient Accountability
You are expected to be an active participant in your care. Any recommended exercises, stretches, ice/heat applications, life style changes, or other active processes must be followed to ensure optimum progress.

Communication
We are here to serve you. Please speak with Dr. Adisa about anything that could be upsetting you. We value your comments as helping us to help you and others.

After Hours Contact:
Please limit using after hour communication with Back To You for urgent health issues. In the event of an emergency, call 911. If you require after hours communication, contact us at (301)755-1997 .

Please note that these policies are subject to change. You will receive email notification of any such changes made to this agreement. If you have any questions regarding this agreement, please feel free to contact my practice via email dradisa@beltwaychiro.com or (301)755-1997 . I look forward to providing you with the highest quality care.

I, as a patient of Back To You, have read and understand this policy agreement. By signing below, I will abide by its terms.

____
Patient Name

____ ______________
Patient Signature Date

Irrevocable Assignment, Lien and Authorization, and Financial Agreement

I authorize any insurance carrier to pay directly to my physicians such sums as may be due and owing to them. If I directly receive any proceeds of any insurance policy, including but not limited to proceeds from any medical insurance, personal injury protection, and medical payment coverage, I agree to immediately make payment to you upon receipt of those monies.

I do hereby authorize Back To You to furnish my attorney(s) and/or claims adjustors any and all medical information, bills, and records which they may request to all illnesses and injuries suffered by me, my wife, my husband, or children including, but not limited to, the injuries sustained on the date of accident identified below.

I further irrevocably assign to you, and authorize and direct my attorney(s), if applicable, to pay from the proceeds of any settlement, judgment or insurance policy, all reasonable fees for health care services, equipment, supplies, preparation of reports, and testimony provided by you as a result of the injury or condition sustained on the date of accident. I understand that this in no way relieves me of my personal primary responsibility to pay for such services, and that the signing of this form does not prohibit customary billing by you. I further understand that my responsibility to you for payment is not contingent on any settlement, judgment or verdict.

I further authorize my attorney(s) upon your request to notify you of any substantial change in the status of the cause of action related to the illness or injuries described above which would affect my ability to pay for the health care services rendered. I further authorize and direct my attorney(s) to notify you should their representation of my interests in connection with the illnesses and injuries by terminated for any reason.

I further understand that if, for any reason, my attorneys terminate their representation of me related to an accident for which I am receiving care at Back To You, that all invoices for services performed are due and payable immediately, and that I will be billed for any further treatment in normal course. Back To You retains the right to refuse to perform services due to unpaid invoices.

I further understand that because of long delays in trial dockets, many personal injury cases are not tried or settled until a date, which is beyond the three (3) years after the last service was performed. In view of this, I hereby agree that the statute of limitations with respect to any claim for fees for services mentioned above will not begin to run until there is a denial in writing by me of any balance claimed to be due and owing to you by me.

I further agree and understand that any invoice remaining unpaid over 30 days, shall accrue interest at the rate of 5% per annum. I further agree that should Back To You refer this matter to an attorney for collections that I shall pay a $25.00 administrative fee and be responsible for Back To You reasonable attorney's fees in amount no less than 15% of the total principal balance due and owing.

A photocopy of this Authorization shall be as binding as the original.

Date of Accident:____________________________

Patient Name (Printed):____

Guarantor's Name:__________________ Relationship to Patient: _________________

Patients Signature: ____Date Signed: ____________

Patient Address: ____

Attorney/Authorized Representative of Insurance Carrier Acknowledgement and Cooperation Agreement

The undersigned attorney/authorized representative of insurance carrier for the patient referred to above agrees to comply fully with the foregoing "Irrevocable Assignment, Lien and Authorization, and Financial Agreement" and agrees to advise the named Back To You in writing the status of the claim of the patient within five (5) days of the request and agrees to notify the assignee within ten (10) days if the attorney ceases to represent this patient and/or if the claim is dropped or denied. If this case continues beyond fifteen (15) months from the initial date of service Back To You may release the bill for services directly to the patient/guarantor for payment within thirty (30) days.
Attorney/Authorized Representative Name:____

Address: ____

Fax#:_____________________________________Phone#:____

Attorneys'/Authorized Representative Signature:_____________________________ Date Signed: ________________________________